Items 1 and 5 are required. (Please print) Complete other information only if there is a change.

FOR DMA/Fiscal Agent USE ONLY
Date keyed: _____

1. Provider Information

Effective Date of Change:

Medicaid Provider Number (*One provider number per form*): NPI Number (*One NPI number per form*):

Provider Name:		
Type of Provider: ☐ Individual	☐ Group	☐ Carolina ACCESS

2. Type of Change

☐ **Office (Site) Location**		☐ **Billing Location**	
Address (*Attach copy of new Provider Participation Agreement*):		Address:	
City:		City:	
State:	Zip Code + Plus 4 (Required):	State:	Zip Code + Plus 4 (Required):
Office/Site Phone:		Billing/Mailing/Payment/Accounting Phone:	
Fax#:	E-mail:	E-mail:	
Change County to:			

☐ NPI Number (Attach copy of NPPES reflecting NPI number change):
Previous NPI Number: New NPI Number:

☐ Individual Provider Name (Attach a copy of your new license or certification reflecting your name change and a completed IRS Form W-9 or Substitute W-9):
Previous Full Name: New Full Name:

☐ Individual Provider Tax Name (Attach a copy of your new license or certification reflecting your name change and a completed IRS Form W-9 or Substitute W-9):
Previous Tax Name: New Tax Name:

☐ Add or ☐ Delete Individual to/from a Group
(The Group's name and provider number must be entered in Item 1. When adding an individual provider to your Group, attach a Group ECS Agreement with the new individual's provider name, individual N.C. Medicaid provider number and original signature entered in the Group Practice Member Information section.)

First Name, Last Name (Required):	Individual N.C. Medicaid Provider Number (Required):	Individual Medical License Number (CA Providers Only):

☐ Change in bed capacity from _____ beds to _____ beds *(Attach state license reflecting bed capacity change)*

☐ Change in Residential Child Care Treatment Level *(Attach state license and Letter of Endorsement reflecting treatment level change)*

☐ Change in Provider Specialty *(Attach new license and letter requesting new specialty)*

☐ CLIA Certification Renewal *(Attach a copy of your renewed CLIA certificate)*

☐ DEA Certification Renewal *(Attach a copy of your renewed DEA certificate)*

☐ Terminate Medicaid participation due to ☐ Change of Ownership ☐ Other _____
(Attach a letter on letterhead requesting termination)

3. Changes for Carolina ACCESS Providers only:

☐ Change CA practice provider number to: _____
Reason:

☐ Change in contact person's name:

☐ After-hours phone:

☐ Change enrollment restriction information (i.e., ages 15 and up only):

☐ Change enrollment limit from: to:

☐ Add counties served:

☐ Delete counties served: ☐ Other:

To reach the CSC EVC Center, call 866-844-1113.
Mail this form to: CSC EVC Center, P.O. Box 300020, Raleigh, NC 27622-8020 or fax to 866-844-1382.

4. CABHA Affiliation Changes only:

Add (affiliate) an individual outpatient therapy practitioner, physician, or advanced practice nurse to the CABHA:

Provider Name	Medicaid Provider Number	NPI Number	Start Date

Please identify the CABHA service provided by the individual outpatient therapy practitioner, physician, or advanced practice nurse to be added:

☐ Outpatient Therapy ☐ Medication Management ☐ Comprehensive Clinical Assessment

Delete (unaffiliate) an individual outpatient therapy outpatient therapy practitioner, physician, or advanced practice nurse from the CABHA:

Provider Name	Medicaid Provider Number	NPI Number	End Date

Please identify the CABHA service provided by the individual outpatient therapy practitioner, physician, or advanced practice nurse to be deleted:

☐ Outpatient Therapy ☐ Medication Management ☐ Comprehensive Clinical Assessment

Add (affiliate) an attending service to be provided by the CABHA: *To add an attending provider for a service, please complete the CABHA Addendum to Add Attending Services at* http://www.nctracks.nc.gov/provider/providerEnrollment/.

Delete (unaffiliate) an attending service provided by the CABHA:

Attending Provider Name	Medicaid Provider Number	NPI Number	End Date

Please identify the CABHA service provided by the attending provider to be deleted:

☐ Assertive Community Treatment Team
☐ Child and Adolescent Day Treatment
☐ Child Residential Level II-Family/Program Type, III, or IV
☐ Community Support Team
☐ Intensive In-Home
☐ Multi-Systemic Therapy
☐ Opioid Treatment
☐ Partial Hospitalization
☐ Psychosocial Rehabilitation
☐ Substance Abuse Comprehensive Outpatient Treatment Program
☐ Substance Abuse Intensive Outpatient Program
☐ Substance Abuse Medically Monitored Community Residential Treatment
☐ Substance Abuse Non-Medical Community Residential Treatment
☐ Therapeutic Family Services
☐ Targeted Case Management for Mental Health and Substance Abuse
☐ Peer Support

5. Signature

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual provider changes must have the provider's original signature. Authorized agents can only sign for a group change.

Signature of Individual or Authorized Agent _____ Date _____

Printed Name _____ Title _____ Phone Number _____

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